Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

December 21, 2017

Ms. Jeana Lavallee, Manager
Living Well Residence
1200 North Avenue
Burlington, VT 05408-1004

Dear Ms. Lavallee:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on October 30, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 11/14/2017
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0543	A. BUILDING: _____ B. WING _____	C 10/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL RESIDENCE	1200 NORTH AVENUE BURLINGTON, VT 05408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite investigation of 2 complaints and one self-reported incident was completed by the Division of Licensing and Protection on 10/30/17. The following are regulatory findings.	R100	R100)	
R114 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.3 Discharge and Transfer Requirements 5.3.a Involuntary Discharge or Transfer of Residents (2) In the case of an involuntary discharge or transfer, the manager shall: i. Notify the resident, and if known, a family member and/or legal representative of the resident, of the discharge or transfer and the specific reasons for the move in writing and in a language and manner the resident understands at least 72 hours before a transfer within the home and thirty (30) days before discharge from the home. If the resident does not have a family member or legal representative and requests assistance, the notice shall be sent to the Long Term Care Ombudsman, Vermont Protection and Advocacy or Vermont Senior Citizens Law Project. ii. Use the form prescribed by the licensing agency for giving written notice of discharge or transfer and include a statement in large print that the resident has the right to appeal the home's decision to transfer or discharge with the appropriate information regarding how to do so. iii. Include a statement in the written notice that	R114	R114) Moving forward, all involuntary and/or emergency discharges will be made following the procedure outlined by the Vermont DLP. This procedure will include a written notice at least 30 days prior to discharge, which will include a statement regarding the resident's right to appeal the discharge decision. The resident will be allowed to remain at the facility during the appeal. In order to prevent failure to meet these requirements in the	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

MS, APRN House Nurse 11/22/17

R114 - R999 POC accepted 12/21/17 MHiggmsRN/PM

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R114	Continued From page 1 the resident may remain in the room or home during the appeal. iv. Place a copy of the notice in the resident's clinical record. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to issue a discharge notice for Resident #1 containing the required information. Findings include: Per record review Resident #1 had a doctor's visit on 8/6/17, that resulted in an order for performance of a self urinary catheterization. In an interview, on 10/30/17, with the facility acting Manager in training (MIT) and the Registered Nurse (RN) they confirmed that the resident returned from an appointment with instruction to perform self catheterization three times a day, according to the resident. The nurse stated that the resident was often non-compliant in doing the procedure and several days later, a check with the doctor revealed the Resident was to perform the procedure four times a day. The resident developed symptoms of a UTI (urinary tract infection) treated in the emergency room at the local hospital and released. He was re-admitted to the hospital on 8/19/17 with a diagnosis of Urosepsis. The facility reportedly told the Case Manager at the hospital that the resident must be able to self-cath and be compliant before returning to the facility. The acting MIT and the RN both stated that the intent was that the resident could not return to the facility requiring catheterization due to his non-compliance. The MIT confirmed that no	R114	Future, the above mentioned procedure will be followed, and the Vermont DLP will be contacted to ensure resident meets requirement for discharge. Contacting the DLP will also serve to monitor future involuntary discharges, and ensure they are performed appropriately. These corrective actions will be completed by 11/27/17.	

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R114	Continued From page 2 involuntary discharge was issued despite the decision he would not be readmitted with the newly required treatment and the issues with non-compliance.	R114		
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to assure that necessary services were provided or arranged for a resident with medical care needs (Resident #1). Findings include: Per record review and staff interviews Resident #1 returned from a doctor's visit on 8/6/17 with instructions to perform self-catheterization three times a day. The Facility RN states that the doctor's office stated that the resident had been trained at the office as this was not a "skilled" facility and this is a "skilled nursing" task. The RN confirmed that s/he did not observe the resident performing the task or confirm that proper technique was being followed. S/he stated that facility staff were "supposed to observe every catheterization". When questioned further, it was confirmed that staff had not been trained to perform the task correctly and that they were	R126	R126) All reasonable accomodations will be made to meet resident's personal, psychosocial, nursing and medical care needs. Moving forward, all resident self-performed care tasks will be directly observed by RN for confirmation of proper technique. Staff will be trained on proper technique as well, to include what warning signs to look for. If needs cannot be met by RN or staff, home health will be contacted to assist. Continuous and close monitoring of residents with additional nursing and/or medical care needs will be performed and PCP or other provider contacted as situation dictates. These actions will be monitored through thorough charting of new or additional medical needs,	

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R126	Continued From page 3 observing only that the task was performed and the amount of urine obtained. Despite issues of hematuria (blood in the urine), and occasional discomfort while doing the procedure the RN never observed the procedure being done by the resident. Eventually the resident developed symptoms and was hospitalized for urosepsis.	R126	as well as continuous charting of tasks previously described. This corrective action will be completed by 11/27/17.	
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to assure that a written plan of care based on needs and services necessary to maintain well-being was developed for Residents # 1, 2, 3 & 4. Findings include: 1). Per record review the care plan for Resident #1, it did not contain information regarding his/her performance of self-catheterization and the monitoring for complications and infection. 2). Per record review Resident #2 was involved in a resident to resident incident with Resident #3. The record indicates that there were some verbal exchanges between the two residents due to	R145	R145) All resident's care plans will be regularly reviewed and revised as necessitated, especially following a major change in condition or development of new behaviors. Care plans for residents #1, 2, 3 and 4 will be updated to reflect behaviors noted in survey. Moving forward quarterly care plan reviews will be performed by house manager and RN to ensure care plans are up to date and to monitor effectiveness of plan of care. Behavioral care plans will be maintained and updated for all residents, with additional instructions for those residents with PRN medications. These corrective actions will be completed by 11/27/17.	

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R145	Continued From page 4 Resident #2 being uncomfortable with "the way [Resident #3] eats and drinks at the table" and other issues between the two. There is no care plan regarding behaviors for Resident #2 especially as related to encounters with Resident #3. The last incident in May 2017 resulted in a physical incident when Resident #2 hit Resident #3 with a cane and Resident #3 pushed Resident #2 to the floor. 3). Per record review Resident #4 has been in the facility since 12/19/16. In observation, Resident #4 wanders in the common areas of the facility during the day. S/he approaches others, including this surveyor, and stands very close while not speaking. In interview the MIT and RN report that the resident eloped from the facility on 10/28/17 while there was only one staff on duty. The resident was escorted back to the facility by neighbors and the police. R#4 also is described as needing close monitoring due to his/her tendency to put his hands into the food and lack of safety awareness. There is no care plan in the record reflecting these issues. In an interview on the afternoon of 10/30/17 the MIT and facility RN confirmed that there were no care plans available for the above issues.	R145		
R999 SS=B	MISCELLANEOUS 4.13.b Whenever the authority is vested in the governing board of a firm, partnership, corporation, company, association or joint stock association, there shall be appointed a duly authorized qualified manager, however named, who will be in charge of the daily management and business affairs of the home, who shall be fully authorized and empowered to carry out the	R999	R999) Manager in training will replace current manager listed on license. This will be performed by January 31, 2018.	

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R999	Continued From page 5 provisions of these regulations, and who shall be charged with the responsibility of doing so. The manager of the home shall be present in the home an average of 32 hours per week. The 32 hours shall include time providing services, such as transporting, or attendance at educational seminars. Vacations and sick time shall be taken into account for the 32-hour requirement. In the event of extended absences, an interim manager must be appointed. This REQUIREMENT is not met, as evidenced by the following: Based on record review and staff interviews the facility failed to assure that the facility Manager was present in the facility on average 32 hours per week. Findings include: On arrival at the facility, on 10/28/17, when asked if the Manager was present, the direct care staff on duty stated that the Manager was on the way. The facility RN also stated that the Manager would arrive soon. Shortly after, a person arrived who identified as the facility Manager. Then this individual explained that he/she was the Manager In Training, and when asked stated that he/she had been training "about 2 years". In a review of the facility license the individual named as Manager was not the MIT who was present on site. When asked how often the Manager on the license is in the facility the MIT, with the RN present, stated that the manager is in the facility 10-20 hours per week. In a phone call on 11/2/17 the Manager confirmed that s/he is at the facility sometimes more and sometimes less than 10-20 hours per week. In interviews 2 anonymous direct care staff state that the manager is there 1-2 days a week mostly.	R999		